PHYSICIAN AND ALLIED HEALTH PRACTITIONER CREDENTIALING POLICY INDEX

POLICY: KEYSTONE PHYSICIAN AND ALLIED HEALTH PRACTITIONER CREDENTIALING

I. PURPOSE

This policy sets forth the requirements for Physician and Allied Health Practitioner Credentialing, Delegation of Credentialing and Credentialing Compliance.[1]

II. POLICY STATEMENT

It is Keystone's policy that physicians and allied health practitioners shall undergo credentialing as a condition of participation in Keystone's network, and that they not render care or services to Keystone members until they are credentialed and so notified. Notwithstanding this requirement, physician and allied health practitioners may see Keystone members for "allowed exceptions" as noted below. It is also Keystone's policy that physicians and allied health practitioners shall undergo periodic recredentialing.

Keystone's policy recognizes and supports each member's right to seek care outside the credentialed network of participating practitioners, in certain situations. Allowed exceptions for non-participating physicians and allied health practitioners to see Keystone members include the following:

1. In cases of medical emergency, where a prudent lay person would seek urgent or emergency care from the closest available provider of emergency services;

2. In cases where the member or a participating practitioner requests the member receive care from a practitioner not in the network, and where Keystone, through its normal precertification process, approves this request (on the basis of no qualified practitioner being available in the network);

3. In cases where the member's benefit program permits selection of out-of-network practitioners with or without reduced benefit, and the member makes this selection to go to an out-of-network practitioner;

4. In cases where continuity of care with a non-participating practitioner is clinically warranted (e.g. switching care in the middle of a treatment course could potentially jeopardize the member's health). Such continuity of care exceptions are expected to occur when new members join Keystone, or when practitioners are terminated from the network for reasons other than quality of care;

[1] This is Keystone's policy and it can be used as a model policy; however, the language in brackets throughout the policy is specific to Keystone's operations and is not part of the model policy. Keystone plan members and provider participants, including all practitioners within scope, are subject to and may rely only on, Keystone's practitioner credentialing and organizational assessment policies. Any model policy does not control the rights and responsibilities of Keystone plan members, providers or practitioner participants.

5. In cases where required by state or federal law or regulation.

Keystone also recognizes the right of individual practitioners and group practices to choose to participate with some but not all of its benefits programs; further, within practice groups, some practitioners may choose not to contract with Keystone at all. In its contracts with practitioners, Keystone requires participating practitioners to refer members to other in-network, credentialed practitioners, and forbids use of non-credentialed practitioners for coverage, except for reasons related to member rights and certain benefit programs as outlined above.

It is Keystone's policy that all Keystone staff comply fully with current accreditation and regulatory standards for credentialing. In furtherance of this policy Keystone has created Credentialing Policies and Procedures that are designed to ensure compliance with the credentialing requirements of all federal and state laws, regulations and contracts such as Medicare, Medicaid and all applicable federal health programs in which Keystone participates. In addition, the specific credentialing and recredentialing methodology and criteria used by Keystone to accept or reject practitioners are at all times consistent with or more comprehensive than the latest versions of the Standards of the National Committee for Quality Assurance (NCQA), the Center for Medicare and Medicaid Services (CMS) QISMC Standards for Credentialing and Recredentialing, in particular QISMC 3.5 and QISMC Domain 4, and all applicable requirements of state laws and regulations, and federal contracts for the provision of health services. Further, these credentialing policies and procedures are designed to monitor the completeness of the credentialing program, the timeliness of periodic recredentialing, and practitioner and delegate compliance with credentialing.

In order to administer an adequate credentialing program Keystone provides sufficient numbers of adequately trained and supervised staff and adequate material resources. These material resources include a credentialing database that can be queried at the level of the individual practitioner, and can create reports to support the credentialing and recredentialing activities; a secure filing system capable of housing information that supports credentialing and recredentialing; and telephonic and/or on-line access to verification organizations and sanction reports. The Credentialing Policy is reviewed on an annual basis and updated as needed to be compliant with the most recent version of NCQA's accreditation, CMS's QISMC standards, and other applicable state and federal regulations. The Policy and any modifications are approved by the Keystone Board of Directors, and practitioners are notified of any relevant changes.

Finally, Keystone has created a credentialing compliance program to assure that credentialing activities are complete and effective. This program is led by a Credentialing Compliance Officer who is responsible to the Board of Directors and reports the results of monitoring activities to the Board on a regular basis.

In the event a provision of this Policy is in conflict with a state or federal law or regulation, or a directive received from a state or federal regulatory agency, then to the extent of the conflict, the provision shall defer to the law, regulation or directive.

III. SCOPE

Credentialing by Keystone is required for all physicians and all other types of health care practitioners who provide services to Keystone's enrollees and who are permitted to practice independently under State law. A listing of practitioner types covered by the policy is listed in **Attachment 1**. Credentialing by Keystone is not required for health care practitioners who are based at hospitals or hospital affiliated organizations ("hospital-based practitioners"), and who provide services to enrollees incident to services provided in the hospital or hospital-affiliated organization. Credentialing by Keystone is required for hospital-based practitioners who are separately identified in the Keystone directory or literature or who maintain an independent contract with Keystone.

IV. RESPONSIBILITY

The Keystone Board of Directors has ultimate responsibility for the Physician and Allied Health Practitioner Credentialing Policy. They delegate oversight of the Policy to the Managed Care Quality Improvement Committee (MCQIC). MCQIC in turn delegates implementation to the Chief Medical Officer. The Chief Medical Officer is responsible for the development of the Physician and Allied Health Practitioner Credentialing Policy and assures that the Policy is approved by the regional Quality Council, Managed Care Quality Improvement Committee and the Keystone Board of Directors and is communicated throughout the organization and to practitioners. This Policy is reviewed on an annual basis. In addition, interim modifications may be required to comply with changes in regulatory requirements or directives as noted above, or to meet business requirements to preserve network integrity or maintain access to services. At all times, the most current Policy will direct the credentialing process. Practitioners are notified of any relevant changes via the newsletter, direct mail or updated Physician Office Manual inserts, as applicable.

The Chief Medical Officer or designee will establish a credentialing committee(s), to include participating, practicing practitioners that will review credentialing applications and recredentialing profiles and make credentialing and recredentialing determinations.

Procedure

The Vice President Quality Management is responsible for the credentialing and timely recredentialing process within Keystone. The Director of Quality Management Operations and the Manager of Credentialing, with oversight by the Vice President Quality Management, ensure that desk procedures for credentialing functions that are managed by Keystone are developed, implemented and maintained, consistent with this Policy, and all applicable State and Federal laws and regulations and CMS and NCQA standards.

The Credentialing Manager ensures that desk procedures pertaining to corporate functions and verifications are current and that credentialing associates adhere to policies and procedures.

The Physician & Allied Practitioner Credentialing Committee is a sub-committee of the Clinical Quality Committee (CQC). The Chiropractic Credentialing Committee is a sub-committee of the Physician & Allied Practitioner Credentialing Committee. These Committee(s) approve or deny

participation based upon thoughtful consideration of the application, supporting documents, and credentials' verification results.

V. IMPLEMENTATION

A. Credentialing

The Credentialing Department implements the credentialing process under the direction of the Director of Quality Management Operations.

The Credentialing Manager ensures that the practitioner application is processed according to established desk procedures. The Credentialing Manager coordinates the timely and appropriate flow of information between Network Services, Quality Management, and the Credentialing Departments; and a Credentials Verification Organization ("CVO") when applicable. The Network Services Department ensures that current and complete documentation is forwarded to the Credentialing Department to facilitate timely credentialing. Delegation Oversight coordinates timely and appropriate flow of information between the delegated entity and the Credentialing Department.

Applicants meeting credentialing criteria are presented to the Physician and Allied Practitioner Credentialing Committee or the Chiropractic Credentialing Committee for review and determination. Applicants that do not meet credentialing criteria are reviewed by the Chief Medical Officer or designee prior to the Committee meeting. The Chief Medical Officer or designee may request additional information and/or make recommendations to the Committee.

Applicants have the right to review information submitted in support of their application with the exception of references or recommendations or other information that is peer review protected. If the credentialing staff identifies a discrepancy between information submitted by the applicant and information received during the verification process, the staff seeks clarification from the applicant. The applicant has the right to correct any erroneous information within thirty (30) days of the request for clarification by Keystone. Corrections and explanations are to be submitted in writing to the Manager of Credentialing.

Practitioners are recredentialed every two (2) years to assure that time limited documentation is updated; that changes in health and legal status are identified; and, that practitioners comply with Keystone's guidelines and processes; and to assess practitioner performance. Failure to complete timely recredentialing results in administrative termination from the network.

Applicants have the right to appeal denials of participation to the Credentialing Committee. Appeals of terminations of participation that are based on the quality and/or competence of the practitioner are addressed in the Due Process Procedure.

All information collected during the credentialing/recredentialing process is kept confidential in accordance with the corporate Confidentiality Policy.

Keystone may elect to delegate verifications of credentials to an external NCQA accredited CVO for credentialing verification with the approval of the Vice President Quality Management. If

delegation of credentials verification to an external CVO is considered, the Corporate Credentialing Manager assesses the CVO's ability to meet Keystone's credentialing criteria and will assist Plan staff in developing a transition plan.

1. Pre-application Evaluation

Keystone reserves the right to determine Network need based on existing access and availability standards and participation criteria. If a need does not exist, Keystone reserves the right not to accept an application. In the event that the applicant practitioner does not meet participation criteria, the application will not be considered.

2. [Participation Criteria]

Participation criteria are bracketed to indicate that they are discrete from credentialing criteria and as such they are optional and may be deleted, expanded or modified to accommodate specific business requirements of a Plan subject to market or geographic needs.

a. Access and Availability

[Keystone considers practitioners with hospital affiliations (e.g. MD, DO, DDS, DMD, DPM) at participating hospital(s) to ensure member selection alternatives.

Keystone considers practitioners who do not participate in restrictive or exclusive practice arrangements with another managed care entity that would preclude or substantially interfere with accepting patients enrolled in products offered by Keystone.

Certified Registered Nurse Practitioner (CRNP) Practices where CRNPs are independently serving as primary care practitioners are considered for participation within the sole discretion of Keystone and/or in accordance with applicable law.

Adequate access and availability (hours of operation and after hours coverage) as determined by Keystone must be provided (Attachment 2).

b. Board Certification

Primary Care and Specialty Physicians must be Board Certified in their area of practice. When network need requires the services of a non-Board Certified practitioner, a Medical Director reviews the application to ensure that training equivalent to a full residency (for primary care physicians) or a fellowship in the specialty area of practice (for specialists) has been completed.

In the event that an application does not meet participation criteria, the application is forwarded to the Vice President Quality Management, or designee, who will determine network need. If network need is established, the Vice President Quality Management, or designee, documents the decision and returns the application to Network Services for routine credentialing.

No appeal rights are available as a result of the Pre-application determination except as otherwise required by state law.]

3. Credentialing Criteria

Physicians and other health care practitioners covered under the scope of this policy are credentialed according to the following criteria.

3.1 Application: A complete, signed and dated application including but not limited to information regarding the following must be submitted:

3.1.1 work history for immediate previous five (5) years from the date the application was signed including month and year with a written explanation of gaps greater than six (6) months;

3.1.2 education and training completed

3.1.2.1 Physicians: medical school and residency training or fellowships completed;

3.1.2.2 Chiropractors: chiropractic school (Council of Chiropractic Education (CCE) School), residency training and fellowships completed; the applicant must successfully complete all sections of the National Chiropractic Board Exam (NCBE) as applicable to state law and regulation;

3.1.2.3 Podiatrists: podiatry school, and any residency training and fellowships completed;

3.1.2.4 Dentists and Oral Surgeons: dental school, residency training and fellowships completed;

3.1.2.5 Midwives: graduate and post-graduate education must include successful completion of an accredited education program for this specialty.

3.1.2.6 Optometrists: completion of an accredited training program in optometry. The applicant must also pass the National Board of Examiners in Optometry (NBEO).

3.1.2.7 Other health care practitioners: graduate and post-graduate education and training.

3.1.3 a statement of chemical dependency/substance abuse;

3.1.4 loss or limitation of license/or felony convictions;

3.1.5 loss or limitation of hospital privileges or disciplinary action;

3.1.6 reasons for any inability to perform the essential functions of the position; with or without accommodation;

3.1.7 an attestation to the correctness and completeness of the application;

3.1.8 an attestation that the applicant, if accepted, will make no referrals to practitioners who are not fully credentialed, except as noted above under "allowed exceptions," and

3.1.9 a signed and dated Authorization for Release of Information (credentialing warranty) must be included.

3.2 License: Physicians and other healthcare practitioners must have current unrestricted license(s), and additional certifications where required, to practice his/her profession and specialty. A copy of current license(s) and applicable certifications must be submitted with application when required by state or federal law or regulation.

1.2.1 Therapeutic Optometrists must also have a Therapeutic Pharmaceutical Agent (TPA) license.

3.3 Board Certification:

3.3.1 Physicians: must be Board Certified as recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in compliance with Credentialing Standards of the National Committee for Quality Assurance in the area of practice except as follows:

3.3.1.1 Exception is noted for non-Board Certified applicants as described in the Pre-application Evaluation participation criteria.

3.3.2 Chiropractors: not applicable.

3.3.3 Podiatrists: must be certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics & Primary Podiatric Medicine.

3.3.3.1 Exceptions for non-board certified podiatrists are considered as described in the Pre-application Evaluation participation criteria.

3.3.4 Dentists and Oral Surgeons: not applicable.

3.3.5 Midwives: must demonstrate evidence of appropriate certification from an accredited education program for this specialty.

3.3.6 Optometrists: not applicable

3.3.7 Other health care practitioners: practitioners who are board certified in the discipline for which they are applying will be verified with the appropriate specialty board or through confirmation with the state-licensing agency. However, verification of board certification through the specialty board cannot be substituted for verification of the education and training.

3.4 DEA Certification:

3.4.1 Physicians: must have current DEA and CDS (as applicable) certification. Copies of the certificate(s) must be submitted with the application as

required by state or federal law/regulations. DEA and CDS certification is optional for pathologists and non-invasive radiologists.

3.4.2 Chiropractors: not applicable.

3.4.3 Podiatrists: must have current DEA and CDS certification as applicable. Copies of the certificate(s) must be submitted with the application as required by state or federal law/regulation.

3.4.4 Dentists and Oral Surgeons: must have current DEA and CDS certifications as applicable. Copies of the certificate(s) must be submitted with the application as required by state or federal law/regulation.

3.4.5 Midwives: Not applicable.

3.4.6 Optometrists: Not applicable.

3.4.7 Other health care practitioners: Not applicable.

3.5 Liability Insurance: Must maintain malpractice coverage specified by the requirements of the state(s) in which the applicant practices. Unless mandated by state or federal law/regulations, the applicant may submit a signed and dated attestation stating the dates and amount of coverage in lieu of a liability face sheet.

3.6 Hospital Privileges:

3.6.1 Physicians: maintain privileges at a minimum of one (1) participating hospital. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

3.6.1.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

3.6.1.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

3.6.2 Chiropractors: Not applicable.

3.6.3 Podiatrists: maintain privileges at a minimum of one (1) participating hospital when scope of practice includes inpatient care. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

3.6.3.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

3.6.3.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

3.6.4 Dentists and Oral Surgeons: maintain privileges at a minimum of one (1) participating hospital. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

3.6.4.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

3.6.4.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

3.6.5 Midwives: must have clinical privileges at a participating network hospital or association with a network birth center. Unless mandated by state or federal law/regulation, the applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

3.6.5.1 Agreement with Collaborating Physician: Applicant must maintain written agreement(s) with collaborating physician(s) in accordance with the requirements of state law and to the satisfaction of Keystone. Applicant's collaborating physician(s) must be a network participating practitioner. The applicant must submit a signed and dated attestation to this effect with their application.

3.6.6 Optometrists: Not applicable.

3.6.7 Other health care practitioners: Not applicable.

3.7 [Site Visit and Medical Record Keeping Review:

3.7.1 Physicians: Site visits are required for all primary care and OB-GYN offices. Compliance with network site standards will be measured using the current version of the site visit review tool, and the overall minimum acceptable score for the site visit review is 80%. In addition, the practitioner must comply with urgent and emergent as well as after hours

access standards, as determined by Keystone. If the overall score for a site visit is greater than 80 but deficiencies are identified that require a corrective action plan, then site visits will be performed every six (6) months until the deficiencies are corrected. A site visit is performed whenever an applicant or participating practitioner opens a new site or moves to a site that is currently not an approved site. Additional site visits may be performed based on identified quality issues reported to Network Services and/or Quality Management.

3.7.2 Chiropractors: Not applicable.

3.7.3 Podiatrists: Not applicable.

3.7.4 Dentists and Oral Surgeons: Not applicable.

3.7.5 Midwives: Site visits are required for all midwife offices. Compliance with network site standards will be measured using the current version of the site visit review tool, and the overall minimum acceptable score for the site visit review is 80%. In addition, the practitioner must comply with urgent and emergent as well as after hours access standards, as determined by Keystone. If the overall score for a site visit is greater than 80 but deficiencies are identified that require a corrective action plan, then site visits will be performed every six (6) months until the deficiencies are corrected.

A site visit is performed whenever an applicant or participating practitioner opens a new site or moves to a site that is currently not an approved site. Additional site visits may be performed based on identified quality issues reported to Network Services and/or Quality Management.

3.7.6 Optometrists: Not applicable.

3.7.7 Other health care practitioners: Not applicable.]

3.8 Coverage:

3.8.1 Physicians: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering physicians may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.8.2 Chiropractors: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering physicians may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.8.3 Podiatrists: offer coverage twenty-four (24) hours a day, seven (7) days-a-week coverage. A participating same or similar specialty practitioner must provide coverage. Covering practitioners may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.8.4 Dentists and Oral Surgeons: offer coverage twenty-four (24) hours-a-day, seven (7) days-a-week. Coverage must be provided by a participating same or similar specialty practitioner. Covering dentists may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.8.5 Midwives: offer coverage twenty-four (24) hours-a-day, seven (7) days-a-week. Applicant must also have documented arrangements for the provision of emergency physician consultation, emergency treatment, and emergency inpatient hospital care using a network participating hospital.

3.8.6 Optometrists: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering physicians may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.8.7 Other health care practitioners: mental health practitioners must offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering practitioners may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

3.9 Malpractice History: Practitioner must provide a report detailing professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner during the prior five (5) years, beginning with the date of the signature on the application.

3.10 All applicants must be currently eligible to receive payment under Medicare/Medicaid and Federal Employees Health Benefit Plan (FEHBP).

V.A.4. Action

4.1 For physicians and other health care practitioners covered under the scope of this policy, primary verification is performed for:

4.1.1 License;

4.1.2 DEA;

4.1.3 CDS;

4.1.4 hospital privileges at the primary facility (when applicable) when an attestation is not sufficient per state or federal law/regulation;

4.1.5 Board Certification;

4.1.6 training and/or education for non-boarded practitioners;

4.1.7 residency and fellowship as applicable;

4.1.8 the National Practitioner Data Bank (NPDB) and HIPDB, as applicable, are queried for all practitioners;

4.1.9 a liability face sheet is reviewed to ensure appropriate coverage and expiration dates when an attestation is not sufficient.

4.2 For physicians and other health care practitioners covered under the scope of this policy the following will be completed:

4.2.1 The applicant's immediate past five (5) year work history from the date the application was signed is reviewed but not primarily verified. Work gaps of six (6) months or greater are identified and the practitioner is required to explain these gaps in writing.

4.2.2 The history of closed professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner are reviewed for the past five years from the date of the application signature.

4.2.3 Applicant is evaluated for disciplinary action. NPDB and HIPDB are the verification source for Medicaid/Medicare sanctions as well as for sanctions or limitations on licensure. State licensure boards are also a source of information on sanctions. The FSMB and CIN-BAD queries are made on M.D., D.O., and D.C. practitioners when the practitioner has practiced in another state within the past five (5) years or the practitioner practices in two (2) or more states concurrently.

4.2.4 Applicants, with incomplete applications or when discrepancies are identified during the credentialing verification process, are contacted and will be given thirty (30) days to provide the required information after which the application will be closed out as incomplete and efforts to credential will cease.

V.A.5. Committee

5.1 Credentialing support staff review the completed application file, including documents and verifications, prior to presentation to the Committee. The individual staff member responsible for each of the activities under 4.1 and 4.2 above will sign the file attesting to the completion of the primary verification, as applicable. The file is also reviewed by the Vice President Quality Management

or designee as specified in the Credentialing Criteria when the credentialing staff identifies an area of concern.

5.2 Credentialing Committee will make one of the following determinations:

5.2.1 Approved: Applicants meet all participation and credentialing criteria requirements. Individual credentialing files reflect verification of all requirements including site visits as applicable.

5.2.2 Denial: Applicants who fail to meet all participation and credentialing criteria requirements resulting in denied participation in the network(s).

5.2.2.1 A practitioner is notified that he/she has been denied participation by certified mail including the ability to submit a written appeal with additional information, as appropriate, within thirty (30) days of the date of denial notification letter. Appeals received after thirty (30) days will not be accepted.

5.2.2.2 Within thirty (30) days of receipt of the appeal, the Credentialing Committee will review the submitted information and determine status. If a denial is upheld, the decision is final and binding. The practitioner is notified within five (5) business days of the determination via certified mail.

5.2.2.3 Tabled: Applicant or practitioner may be tabled if the Credentialing Committee determines that additional information is needed. The committee will evaluate all credentials at the time the additional information is obtained. All documentation must be current within 180 days at the final review.

5.2.2.4 Provisionally Approved: Applicants who have completed their residency or fellowship requirements within the twelve (12) months before the credentialing decision, may because of unavailable documentation regarding former completion of training, be provisionally approved for no more than sixty (60) days provided the following:

5.2.2.4.1 Primary source verification of a current, valid unrestricted license to practice prior to granting the provisional status.

5.2.2.4.2 Confirmation of the past five (5) years of malpractice claims and/or settlements from the malpractice carrier or the results of the NPDB query prior to granting provisional status.

5.2.2.4.3 Submission of a completed and signed attestation.

5.2.2.4.4 If after sixty (60) days full documentation is not received, the applicant will be denied.

V.A.6. Network

6.1 Keystone sends each approved applicant written notification of approval.

V. B. RECREDENTIALING

Recredentialing shall occur every two (2) years; which time period shall be calculated from the date of the most recent credentialing committee approval. Keystone shall maintain a recredentialing database to identify when practitioners are due for recredentialing and to provide timely notice to practitioners regarding recredentialing applications.

Ongoing and systematic monitoring of practitioner performance is conducted by Quality Management in collaboration with the Network Services Department. These activities may include, but are not limited to: [a) completion of additional site visits when opportunities for improvement are identified on an initial site visit or the practitioner has relocated or opened a new site that has not previously been approved], b) review of practitioner specific quality of care and quality of service member complaint data and other related provider improvement activities, c) general medical record review for primary care physicians and d) profiling information. This information is forwarded to the Credentialing Department for inclusion in the recredentialing file prior to consideration and determination.

Ongoing monitoring activities also include the monthly review of the Office of Personnel Management (OPM) Report, the Health and Human Services Office of the Attorney General (OIG) Report, and the State Board sanction reports for evidence of sanctions or for any limitations placed on a practitioner's licensure or eligibility to participate in any Medicare/Medicaid or Federal Employees Health Benefit Plan (FEHBP). This review is performed concurrent with publication of each of the aforementioned reports.

V.B.1 Criteria

Physicians and other health care practitioners covered under the scope of this policy are recredentialed according to the following criteria.

1.1 The recredentialing profile, the credentialing warranty (attestation), and Professional Questions must be completed, signed and dated by practitioner.

1.2 The application will include a signed and dated Authorization for Release of Information (credentialing warranty).

1.3 License: Physicians and other healthcare practitioners must have current unrestricted license(s), and additional certifications where required, to practice his/her profession and specialty. A copy of current license(s) and applicable certifications must be submitted with application when required by state or federal law.

1.3.1 Therapeutic Optometrists must also have a Therapeutic Pharmaceutical Agent (TPA) license.

1.4 Board Certification:

1.4.1 Physicians: must be Board Certified as recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in compliance with Credentialing Standards of the National Committee for Quality Assurance in the area of practice except as follows:

1.4.1.1 Exception is noted for non-Board Certified applicants as described in the Pre-application Evaluation participation criteria

1.4.2 Chiropractors: Not applicable.

1.4.3 Podiatrists: must be certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics & Primary Podiatric Medicine.

1.4.3.1 Exceptions for non-board certified podiatrists are considered as described in the Pre-application Evaluation participation criteria.

1.4.4 Dentists and Oral Surgeons: Not applicable.

1.4.5 Midwives: must demonstrate evidence of appropriate certification from an accredited education program for this specialty.

1.4.6 Optometrists: Not applicable.

1.4.7 Other health care practitioners: practitioners who are board certified in the discipline for which they are applying will be verified with the appropriate specialty board or through confirmation with the state-licensing agency. However, verification of board certification through the specialty board cannot be substituted for verification of the education and training.

1.5 DEA Certification

1.5.1 Physicians: must have current DEA and CDS (as applicable) certification. Copies of the certificate(s) must be submitted with the application as required by state or federal law/regulations. DEA and CDS certification is optional for pathologists and non-invasive radiologists.

1.5.2 Chiropractors: Not applicable.

1.5.3 Podiatrists: must have current DEA and CDS certification as applicable. Copies of the certificate(s) must be submitted with the application as required by state or federal law/regulation.

1.5.4 Dentists and Oral Surgeons: must have current DEA and CDS certifications as applicable. Copies of the certificate(s) must be submitted with the application as required by state or federal law/regulation.

1.5.5 Midwives: Not applicable.

1.5.6 Optometrists: Not applicable.

1.5.7 Other health care practitioners: Not applicable.

1.6 Liability Insurance: Must maintain malpractice coverage specified by the requirements of the state(s) in which the applicant practices. Unless mandated by state or federal law/regulations, the applicant may submit a signed and dated attestation stating the dates and amount of coverage in lieu of a liability face sheet.

1.7 Hospital Privileges:

1.7.1 Physicians: maintain privileges at a minimum of one (1) participating hospital. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

1.7.1.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

1.7.1.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

1.7.2 Chiropractors: Not applicable.

1.7.3 Podiatrists: maintain privileges at a minimum of one (1) participating hospital when scope of practice includes inpatient care. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

1.7.3.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

1.7.3.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

1.7.4 Dentists and Oral Surgeons: maintain privileges at a minimum of one (1) participating hospital. The applicant may submit a signed and dated

attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

1.7.4.1 Unless required by state law/regulation, privileges may be waived. The applicant must obtain a collaborative agreement for inpatient coverage from a participating network practitioner of same or similar specialty.

1.7.4.2 Unless required by state law/regulation, privileges may be waived when inpatient care is not within the scope of practice.

1.7.5 Midwives: must have clinical privileges at a participating network hospital or association with a network birth center. Unless mandated by state or federal law/regulation, the applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.

1.7.5.1 Agreement with Collaborating Physician: Applicant must maintain written agreement(s) with collaborating physician(s) in accordance with the requirements of state law and to the satisfaction of Keystone. Applicant's collaborating physician(s) must be a network participating practitioner. The applicant must submit a signed and dated attestation to this effect with their application.

1.7.6 Optometrists: Not applicable.

1.7.7 Other health care practitioners: Not applicable.

1.8 Coverage:

1.8.1 Physicians: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering physicians may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.8.2 Chiropractors: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering practitioners may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.8.3 Podiatrists: offer coverage twenty-four (24) hours a day, seven (7) days-a-week coverage. A participating same or similar specialty practitioner must provide coverage. Covering practitioners may only charge members the

applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.8.4 Dentists and Oral Surgeons: offer coverage twenty-four (24) hours-a-day, seven (7) days-a-week. Coverage must be provided by a participating same or similar specialty practitioner. Covering dentists may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.8.5 Midwives: offer coverage twenty-four (24) hours-a-day, seven (7) days-a-week. Applicant must also have documented arrangements for the provision of emergency physician consultation, emergency treatment, and emergency inpatient hospital care using a network participating hospital.

1.8.6 Optometrists: offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering practitioners may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.8.7 Other health care practitioners: mental health practitioners must offer coverage twenty-four (24) hours a day, seven (7) days a week. Coverage must be provided by a participating same or similar specialty practitioner. Covering practitioners may only charge members the applicable co-payment. Any financial agreement for coverage arrangements is to be made between the practitioners.

1.9 Each practitioner will further attest that no referral will be issued to practitioners who are not fully credentialed except under the provisions outlined above under "allowed exceptions."

1.10 Practitioners must meet the following recredentialing standards for continued participation in the network:

1.10.1 Malpractice History: The number and explanations of closed cases since the last credentialing review;

1.10.2 Maintenance of Standards of Service as monitored by Network and Quality Management;

1.10.3 Current unrestricted license(s) and Medicare/Medicaid/FEHBP eligibility;

1.11 Primary Care Practitioners must also meet performance monitored standards which are incorporated into the recredentialing decision for primary care physicians;

1.11.1 medical record;

1.11.2 site visits (if applicable);

1.11.3 available member satisfaction data for practitioners directly contracted by Keystone; and

1.11.4 the results of Provider Improvement activities such as member complaints, information from quality reviews, and practitioner improvement activities for those under corrective action.

V.B.2. Action

2.1 Primary verification is performed for:

2.1.1 license;

2.1.2 DEA and CDS;

2.1.3 hospital privileges at the primary facility (when applicable) when an attestation is not sufficient;

2.1.4 Board Certification for time limited certifications or recertifications, for practitioners certified since initial credentialing, or for practitioners requesting recognition of a new specialty;

2.2 For physicians and other health care practitioners covered under the scope of this policy the following will be completed:

2.2.1 Liability Face sheet is reviewed to ensure appropriate coverage and expiration dates when an attestation is not sufficient;

2.2.2 The history of professional liability closed claims that resulted in settlements or judgments paid for by or on the behalf of the practitioner and an explanation of same from the practitioner, since the date of signature of the previous application for credentialing or recredentialing;

2.2.3 The practitioner is evaluated for disciplinary or other final adverse actions through approved state and federal regulatory entities via ongoing, monthly monitoring of sanction reports as noted above, including: Office of Personnel Management (OPM), Office of the Inspector General (OIG), various state licensing Boards, FSMB and CIN-BAD as appropriate. NPDB and HIPDB are the verification source for Medicaid/Medicare sanctions as well as for licensure sanctions or limitations.

V.B.3. Committee

3.1 Credentialing support staff review the completed recredentialing application file, including documents and verifications, prior to presentation to the Committee. The individual staff member responsible for each of the activities under 2.1 and

2.2 above will sign the file attesting to the completion of the primary verification, as applicable. The file is also reviewed by the Vice President Quality Management or designee as specified in the Credentialing Criteria when the credentialing staff identifies an area of concern.

3.2 Credentialing Committee will make one of the following determinations.

3.2.1 Approved: Recredentialed Practitioner meets all participation and recredentialing criteria requirements. Individual credentialing files reflect verification of all requirements including site visits as applicable.

3.2.2 Denied: Practitioner fails to meet all participation and recredentialing criteria requirements resulting in termination from the network(s).

3.2.2.1 A practitioner is notified that he/she has been denied participation by certified mail including the ability to submit a written appeal with additional information, as appropriate, within thirty (30) days of the date of denial determination letter. Appeals received after thirty (30) days will not be accepted.

3.2.2.2 Within thirty (30) days of receipt of the appeal, the Credentialing Committee will review the submitted information and determine status. If a denial is upheld, the decision is final and binding. The practitioner is notified within five (5) business days of the determination via certified mail.

V.B.4. Network

4.1 Keystone notifies each practitioner in writing of a denial determination, which includes any relevant appeal rights.

Failure to comply with the recredentialing process will result in administrative termination. Practitioners who exceeded the twenty-four (24) month cycle but who wish to continue participation must apply as a new practitioner. All pre-application and credentialing criteria will apply.

V. C. Monitoring Activities

The Chief Medical Officer or his designee prepares reports regarding the productivity, timeliness, and accuracy of the credentialing and recredentialing process, including the activities listed below, whether performed by Keystone or its delegate. These reports are reviewed by the Credentialing Compliance Officer, and presented to the Quality Council, MCQIC and Board of Directors on a semi-annual basis. In addition, to monitor group practice compliance with credentialing, Keystone annually provides each group practice with a list of all known credentialed practitioners in the group, and notifies the group of any changes to the list as they occur. Also, Keystone requires each practitioner (on application dates and with each recredentialing) and each practice group (on an annual basis) to attest to compliance with its

contractual obligations. Keystone has created a hot line whereby members or practitioners can report concerns about credentialing. Finally, Keystone will match its claim database against its credentialing database to identify any potential credentialing failures.

1. Lists and Rosters

Keystone will provide each group practice in its network annually with a list of all known credentialed practitioners in the group. Like attestations, this activity increases the groups' awareness of the need to direct members to these practitioners, and allows the group to monitor the status of its panel. In addition to annual lists, Keystone will notify the group of any changes to the list (additions or deletions) as they occur.

Similarly, each group practice will on an annual basis provide to Keystone a roster of all practitioners in the group, designating those that are credentialed and those that are not, and update Keystone as to any changes in the list as soon as they occur.

2. Attestations

Attestations will be required from each group practice on an annual basis, as outlined below:

To increase awareness of the need to comply with Keystone's credentialing requirements, each group practice in the Keystone Network will attest that it will permit only those practitioners who are fully credentialed and/or recredentialed in accordance with the Keystone standards outlined above, to see and treat Keystone members, except as outlined above under "allowed exceptions."

Each group practice also attests that the practice will not permit a practitioner who is undergoing the credentialing process to render services to Keystone members before the completion of the credentialing process, with the limited exception for recent graduates of residency programs. On recredentialing each practitioner attests that he/ she is fully credentialed in accordance with Keystone standards and that this status has been continuously maintained. Each group practice also attests that the practice will not permit a practitioner who has failed to complete the recredentialing process by the two (2) year anniversary of that practitioner's original credentialing approval or most recent recredentialing approval to render services to Keystone members until completion of the recredentialing process. Finally, each group practice attests that it will immediately notify Keystone of any potential credentialing or recredentialing violation immediately upon discovery of the same.

3. Hotline

In order to provide access to members, practitioners and others wishing to express concerns or report suspected violations, Keystone maintains a credentialing hotline, available through a toll-free telephone line and e-mail. The existence of the hotline is advertised to members, practitioners and practice groups and the use of this vehicle is invited. Matters can be reported on an anonymous basis without fear of retribution. The Credentialing Compliance Officer maintains records of reported allegations and credible allegations will be investigated.

Reports of any such investigation are included in the Credentialing Compliance Officer's report to the Board of Directors.

4. Directories

Hard copy directories that list credentialed and participating practitioners, including practitioners of delegated entities, are made available to members upon request by contacting Keystone Member Services telephonically or in writing. Additionally, a listing of credentialed and participating practitioners is made available by contacting Keystone telephonically at a toll free number or by accessing the Keystone web-site.

5. Monitoring Of Keystone's Credentialing Database

Keystone maintains a network-wide database of all fully credentialed practitioners in its network, including all those within a delegated entity, except where the delegated entity has its own fully credentialed practitioner database, inclusive of all disciplines and specialties. This database is routinely updated each week and updated daily for all terminations for cause, and is accessible to all members, practitioners, group practices and sites in the network for use in verifying fully credentialed practitioners in the network. Such access includes toll free telephone numbers and the Internet, at a publicized web address.

6. Comparison Of The Claims Processing Database With The Credentialed Database

Keystone maintains both a database of fully credentialed providers (including those providers within a delegated entity) and a claims processing database (including claims from providers in delegated entities to whom claim processing has not been delegated). The fully credentialed practitioner database includes individual provider claim identification numbers for each provider who is fully credentialed ("valid individual provider claim identification number"). In order to ensure that treatment is being rendered to Keystone patients by fully credentialed practitioners, Keystone will perform a monthly database match of its claims processing database and its fully credentialed database as follows:

a. Each month Keystone will perform an initial claims review of all claims in the Keystone claims database to determine whether the service was rendered by a provider with a valid individual performing provider identification number. If the claim does not include an individual performing provider identification number, Keystone will return the claim to the provider to have the information completed. In the event the provider does not provide a valid individual performing provider identification number, Keystone will treat the claim as one containing an invalid performing provider identification number.

b. Each month Keystone will perform an additional review of all claims which contain invalid performing provider identification numbers to determine if an allowable exception, as set forth on p. 1, is applicable. If an allowable exception is applicable, Keystone will take no further action to investigate the claim.

If there is no applicable allowable exception, the claim represents a potential credentialing failure. During the 30 days of the initial claims review Keystone must determine if a potential credentialing failure occurred and, if so, the Section relating to violations of Keystone's credentialing policies applies.

VI. DELEGATION OF CREDENTIALING AND RECREDENTIALING

A. Delegation

Keystone recognizes that it has responsibility for credentialing . However, Keystone will, in some specific instances delegate credentialing to another entity. Notwithstanding delegation, Keystone retains authority and responsibility for credentialing.

Prior to executing a contract or delegation agreement for delegated credentialing, Keystone determines the capacity of the potential delegate to assume responsibility for credentialing and to maintain Plan standards. An initial assessment of the Delegate's credentialing process and capacity to assume delegated credentialing will include at a minimum an assessment of the resources devoted to credentialing and recredentialing, a review of all policies and procedures in effect, and a review of files against applicable standards. This includes using the NCQA-MBHO data collection tools or similar tools for assessing capacity when delegation is to a Behavioral Health Organization. Specific oversight activities are listed below under "Oversight of Delegated Credentialing/Recredentialing Activities." Where potential delegates do not meet the required standards a corrective action plan is provided in order to allow the potential delegate to remedy deficiencies. Following this audit, Keystone undertakes its own internal review process of the delegates' readiness, including review and approval by the Chief Medical Officer or designee and by the Delegation Committee.

When delegation does occur, Keystone will implement oversight procedures including ongoing monitoring and the annual assessment of the Delegate's credentialing process described below to monitor compliance with all credentialing requirements. The Delegation Committee monitors the Delegate's compliance with standards. Annually Keystone may provide available profiling information for the Delegate's recredentialing process.

B. Sub-delegation

The Delegate may not sub-delegate credentialing without a mutually agreed upon document between the Delegate and the sub-delegate, and approval by Keystone prior to the implementation of sub-delegation. Keystone determines whether they or the Delegate will directly monitor the sub-delegate's compliance with delegation requirements. In any event, the subdelegate is required to comply with all of the requirements of the delegate.

C. Delegation Contract/Addendum

The contractual language between Keystone and the Delegate(s) specifies: i) the delegated activities ii) the Delegate's accountability for these activities, iii) the reporting frequency to Keystone and iv) the process by which the delegation will be evaluated including the

circumstances under which delegation may be revoked. Keystone assures that a sub-delegation agreement meets the above requirements.

Keystone retains the right to approve the delegate's credentialing and recredentialing policies and procedures for consistency with Keystone's policies and procedures, State and federal law and NCQA standards; approve new practitioners and sites; and, to terminate or suspend practitioners from participation in Keystone's benefit programs.

At a minimum the delegate agrees to implement the following:

D. Credentialing Policy and Criteria:

The Delegate must have a Credentialing Policy that is consistent with Keystone's policy and use credentialing and recredentialing criteria that comply with those of the NCQA and the CMS QISMC Standards for Credentialing and Recredentialing, in particular QISMC 3.5 and QISMC Domain 4, as well as all applicable requirements of State law and regulation, and Federal contracts for the provision of health services.

E. Delegate's Monitoring Procedures

1. Attestations

Each delegated entity will implement a group and individual attestation program consistent with Keystone's.

2. Lists and Rosters

Each delegate will provide each group practice in its network annually with a list of all known credentialed practitioners in the group. Like attestations, this activity increases the group's awareness of the need to direct members to these practitioners, and allows the group to monitor the status of its panel. In addition to annual lists, the delegate will notify the group of any changes to the list (additions or deletions) as they occur.

Similarly, each group practice will on an annual basis provide to the delegate a roster of all practitioners in the group, designating those that are credentialed and those that are not, and update the delegate as to any changes in the list as soon as they occur.

3. Delegated Entities To Which Both Credentialing and Claims Processing are Delegated

Keystone delegates both credentialing and claims processing to some entities. All delegates to which both credentialing and claims processing have been delegated must comply with all of the above provisions.

In addition, those entities to which both credentialing and claims processing have been delegated must also comply with either of the following:

a. Comparison of the Claim processing and Capitation Databases with the Fully Credentialed Practitioner Database

Each quarter the delegated entity must take all records from its claim processing and capitation processing databases, remove those records relating to allowable exceptions as set forth on p. 1 and perform a cross match with its fully credentialed practitioner database. The purpose of the cross match is to identify any and all claims submitted by practitioners or capitation paid to practitioners who are not included in the delegate's fully credentialed database. The delegate must immediately report such mismatches to Keystone, which will then follow the action steps outlined in Section relating to violations of Keystone's credentialing policies.

b. Treatment Record Audits

On an annual basis, each delegated entity must audit treatment records of 50% of each of the group practice sites where care is rendered , so that over a two year period 100% of the group practice sites are audited. The delegated entity must select a representative random sample of at least 10 patient_treatment records at each group practice site where care is rendered and verify that each practitioner who rendered care to the patient was fully credentialed at the time the service was rendered. In the event that the delegated entity's audit reveals any practitioner rendering service who was not fully credentialed at the time of the service (and the allowed exceptions set forth on p. 1 of the this Policy are not applicable), the delegated entity must immediately notify Keystone of the situation. Keystone will then follow the actions steps outlined in the section relating to violations of Keystone's credentialing policies.

4. [Comparison of the Claim Processing and Capitation Databases for Behavioral Health

Behavioral Health Delegates are required to carry out matching of claims against the applicable credentialing database. Each quarter, the Behavioral Health Delegate takes all records from its HMO claim processing database and its capitation processing data base, removes those records relating to legitimate out-of-network care and performs a cross match with its fully credentialed practitioner database. The purpose of the cross match is to identify any and all claims submitted by practitioners or capitation paid to practitioners who are not found in the delegate's fully credentialed practitioner database and presumably have not been credentialed by the delegate. All such situations are investigated by the delegate to determine if they are allowed exceptions, and then those that are not shall be reported to Keystone as credentialing failures. The delegate will impose sanctions as outlined below, and report this action to Keystone.][2]

5. Reporting

The delegate's reporting requirements include: annual comprehensive reports to the Chief Medical Officer or designee, and monthly and/or quarterly reports summarizing the monitoring activities completed during the month or quarter.

6. Access

[2] In the event that Keystone chooses not to follow the provisions in paragraph VI, E, 4, behavioral health delegate(s) shall be treated as any other delegate in this Policy.

Each delegate is obligated to provide Keystone full access to all documents generated in the credentialing process and all medical records pertaining thereto consistent with state and federal law and regulation.

VII. OVERSIGHT OF DELEGATED CREDENTIALING/RECREDENTIALING ACTIVITIES

In order to ensure effective oversight of credentialing by a delegated entity, Keystone will perform annual on-site visits of each delegate to:

A. Assess that each delegated entity's credentialing policies and procedures meet regulatory requirements and the policies contained herein;

B. Audit a sample of at least thirty (30) of the delegates' actual credentialing and recredentialing files for compliance with regulatory requirements and the policies contained herein;

C. Assess the adequacy of staffing and other resources, including verification if applicable that the delegate can adequately perform database matching of its claims processing and capitation databases with its fully credentialed practitioner database;

D. Assess the delegate's ability to continue to perform the delegated activities in the coming year;

E. Audit the effectiveness of the delegate's attestation program;

F. Audit the effectiveness of the delegate's List and Roster program;

G. Audit the treatment record review process, as applicable. Keystone will review a random sample of 20 treatment records from the sample of records reviewed by the delegate. Such review will be done at the delegate's office if copies of the treatment records are available there, or at each applicable practice site. Keystone's review will independently verify that each practitioner rendering care to the member was a fully credentialed practitioner, at the time care was rendered, and match these results against those in the delegate's review. Keystone will also verify that the methods used by the delegate to sample treatment records for review produce a non-biased, representative sample (e.g. random sample). Substance abuse records will not be part of Keystone's review;

H. Audit the effectiveness of the database matching, as applicable. Keystone will review a random sample of 20 claims to determine whether the practitioners listed on the claims as having provided service to Keystone enrollees were fully credentialed at the time service was rendered. Keystone will also review the process the delegate uses to perform its comparison of the claims and capitation databases with its credentialed database.

In carrying out audits of the performance of entities to whom credentialing has been delegated, Keystone will employ, at a minimum, the latest version of the NCQA data collection tools for MCOs or MBHOs, as applicable.

VIII. COMPLIANCE VERIFICATION

Assuring that Keystone's credentialing and recredentialing policies are effectively implemented is the responsibility of the Credentialing Compliance Officer who is responsible to the Board of Directors and reports the results of monitoring activities to the Board on a regular basis. Implementation of the policy is the joint responsibility of the Credentialing Compliance Officer and the Chief Medical Officer, who have the following duties:

A. Chief Medical Officer

The Chief Medical Officer monitors the adequacy of the following activities:

1. Recruitment of credentialing staff and training in credentialing standards, policies and desk procedures, including primary source verification;

2. Maintenance of Credentialing policies and procedures and verification procedures, and Desk manuals for credentialing policies and procedures;

3. Management of files and records in compliance with Keystone's document retention policies;

4. Investigations, carried out with the Credentialing Compliance Officer, of allegations relating to provision of services by a non-credentialed practitioner or other violations of Keystone's credentialing compliance policy.

B. Credentialing Compliance Officer

The Credentialing Compliance Officer will be specifically responsible for the following activities:

1. Undertake, along with the Chief Medical Officer, the independent investigation of allegations relating to provision of services by a non-credentialed practitioner or other violations of Keystone's credentialing compliance policy;

2. Monitor and review the Credentialing Compliance Program to ensure that it is updated and modified as needed;

3. Develop and facilitate suitable audits for the credentialing function including, but not limited to, those described below;

4. Provide regular reports to the Board of Directors.

IX. VIOLATIONS OF KEYSTONE'S CREDENTIALING POLICIES

A. Definitions

1. Non-credentialing event - the discovery of a practitioner who requires credentialing but is not credentialed.

2. Non-credentialed practitioner - practitioner who requires credentialing but is not credentialed.

B. Types Of Non-Credentialing Events

The following list is intended as examples of types of credentialing failures but is not intended to be exclusive or exhaustive.

1. Never-credentialed: practitioners who have never been credentialed;

2. Late for re-credentialing: practitioners who have been credentialed but are overdue for recredentialing;

3. Non-Credentialable: practitioner who does not meet one or more of Keystone's credentialing criteria and cannot be credentialed;

4. Fraudulent Credentials (discovered late): practitioner who deliberately presented false credentials to Keystone, or delegate;

5. Fraudulent activity by groups: group practices who deliberately misrepresent non-credentialed practitioner(s) as credentialed practitioner(s) for the purpose of providing in-network services;

6. Fraudulent Activity by Keystone employee or associate: Keystone employee or associate who deliberately creates or conceals credentialing errors or omissions;

7. Fraudulent Activity by a Keystone delegate or subcontractor: Delegate or subcontractor deliberately creates or conceals credentialing errors or omissions;

8. Errors and Omissions: non-deliberate actions or omissions by practitioner(s), groups, delegates, or Keystone staff that lead to non-credentialing events.

C. Actions Taken

If as a result of the monitoring activities noted in Keystone's Credentialing Policy or through any other procedure, a practitioner who requires credentialing or recredentialing is found to be non-credentialed, Keystone, or its delegate on Keystone's behalf, will do the following:

1. Issue, via fax, followed by a certified letter, an immediate cease and desist notification concerning new or existing Keystone patients to the practitioner and to the head of his/her practice with copies to the Chief Medical Officer of Keystone; any exception to this

requirement will be made only for clinical continuity reasons consistent with and as required by law or regulation and with written approval of Keystone's Chief Medical Officer;

2. Notify the practitioner and group that care given by practitioner to Keystone's patients cannot be resumed until full credentialing, including approval by the Credentialing Compliance Officer, is completed (except for clinical continuity as noted above);

3. Notify the Credentialing Compliance Officer immediately, who will undertake an independent investigation into the circumstances of the violation consistent with the procedures outlined below;

4. The Credentialing Compliance Officer will consistently conduct and document each investigation, each decision, and each action taken, to the extent practical, in accordance with Keystone's overall Compliance program;

5. The Credentialing Compliance Officer will make recommendations or remedial measures to the Chief Medical Officer and will monitor whether those measures are adopted;

6. The Credentialing Compliance Officer will report the results of the investigation and any remedial measures taken as a result of the investigation to the Compliance Committee and the Board of Directors as part of his/her regular reporting obligations.

D. Sanctions For Non-Credentialing Events

When a Non-Credentialing Event results in patient(s) being seen by non-credentialable practitioners (those who do not meet Keystone's credentialing criteria) or when fraud is detected as described in numbers 4-7 of the Types of Non-Credentialing events listed herein, Keystone will, in addition to the actions listed above, undertake the review and sanctions in this section. The Chief Medical Officer will immediately notify the patient(s) seen by the practitioner of this fact. The notification will include the member's right to continuity of care consistent with and as required by law or regulation. The Chief Medical Officer will also impose the following sanctions:

1. A full quality of care review of the patient(s) seen by the practitioner in question;

2. Reimbursement by the practice or practitioner of all co-pays and all third party payments - Government and/or private;

3. Reinstatement of exhausted benefits;

4. Provision of gratis medical care where appropriate;

5. Imposition of financial penalties to the extent authorized by contract;

6. Termination of contracts of individual providers;

7. Disciplinary measures up to and including termination with regard to employees, group practices, contractors and/or agents;

8. Notification of regulatory agencies, including but not limited to, medical boards and the department of health of the facts of the credentialing failure consistent with and as required by law and regulation;

9. If the investigation verifies fraudulent activity, as described above, by the practitioner, Keystone will immediately terminate the practitioner from the network;

10. If the investigation verifies fraudulent activity by the group Keystone will immediately terminate the group from the network;

11. If the investigation verifies fraudulent activity by a member of Keystone staff the staff member will be immediately removed from Keystone employ;

12. If the investigation verifies fraudulent activity by the Delegate, or subcontractor, the Chief Medical Officer will immediately terminate the delegation of credentialing.

When a Non-Credentialing Event occurs and where the practitioner is otherwise credentialable the Chief Medical officer may recommend lesser sanctions than those set out above such as financial penalties and remedial training and education for the first offense. Repeat offenses may result in termination.

X. KEYSTONE'S OVERSIGHT OF ORGANIZATIONAL PROVIDERS' CREDENTIALING/RECREDENTIALING ACTIVITIES

In addition to practitioners who contract directly with Keystone or with an entity to which Keystone has delegated credentialing, Keystone enrollees are also treated by practitioners within organizations which have contracted with Keystone.

Although Keystone does not credential those practitioners who practice within organizations (but do not have independent contracts with Keystone) Keystone will perform oversight of the organizations' credentialing process as described below:

A. Scope

Keystone will perform oversight of the credentialing process at all organizations that are not a hospital or a hospital affiliated organization and also at each hospital or hospital affiliated organization that is not accredited by an appropriate accrediting body. Keystone will not perform oversight of the credentialing process at hospitals and hospital affiliated organizations that are accredited by an appropriate accreditation body.

The scope of the oversight will include only those types of practitioners listed in **Attachment 1**. Any practitioner listed in any Keystone literature or directory shall be credentialed by Keystone.

B. Frequency

Keystone will perform its oversight of each organization's credentialing procedures, policies and activities at the time of initial assessment and at each reassessment. Keystone shall reassess 1/3 of its organizations each year so that all organizations are reassessed every three years.

C. Review of Policies and Procedures

Keystone will review each organizations' credentialing policies and procedures to ensure that they contain all necessary elements required by any applicable accreditation body, law or regulation. If Keystone notes deficiencies, Keystone will require a corrective action plan and perform additional reassessments of the credentialing policies and procedures until deficiencies are cured.

D. Audit of Credentialing Files

At each initial assessment and reassessment of each organization, Keystone will obtain a complete list of all practitioners (of types included in **Attachment 1**) who have been credentialed by and affiliated with the organization during the period of time under review. From this list, Keystone will select a random sample of 20 credentialing files. Keystone will perform a site visit to the organization to assess the credentialing operation and will audit the credentialing files of the 20 selected practitioners using the same data collection tool as for delegated entities. Keystone will score this audit and require a corrective action plan until any deficiencies are cured.

E. Audit of Treatment Files

At each reassessment of each organization, Keystone will also select a random sample of 20 treatment records of Keystone members that have been treated at any site of the organization during the period of time under review. Keystone will review those records to determine whether the practitioners (of types included in Attachment 1) who treated Keystone members were credentialed at the time they provided care to Keystone members. Keystone will score this audit and require a corrective action plan until any deficiencies are cured.

F. Violations of Credentialing/Recredentialing Activities of Organizational Providers

If, as a result of the monitoring activities noted in the assessment and/or reassessment of the organizational providers' credentialing activities as outlined above, or through any other procedure, a practitioner who is required to be credentialed or recredentialed by the organizational provider is found to be non-credentialed, Keystone will require the organizational provider to do the following:

1. Investigate the non-credentialing event to determine why the practitioner is not credentialed;

2. Immediately issue a cease and desist notification to prevent the non-credentialed practitioner from providing care to Keystone members during the period of investigation through the time that credentialing is deemed to be completed;

3. Determine if any fraudulent activity was a cause of the non-credentialing event;

4. Perform a quality of care review if warranted by the circumstances;

5. Administer disciplinary measures, up to and including termination, with regards to employees and/or agents if warranted by the circumstances;

6. Notify regulatory agencies, including but not limited to medical boards and/or Department of Health of the facts in the event of a non-credentialing event consistent with and as required by law and regulation;

7. Report to Keystone on the outcome of the aforementioned activities.

In the event that the organizational provider fails to perform these actions in a satisfactory manner, Keystone will implement its own investigation and actions as warranted. Keystone will also, pursuant to the contracts with the organization, implement appropriate disciplinary action.

The disciplinary action will include:

1. Financial penalties for the organizational provider for failure to comply with the credentialing policies to the extent authorized by contract;

2. Requirements that the deficiencies in the credentialing procedures be cured within specified time frames; and

3. Termination of the organizational provider from the Keystone network if fraudulent credentialing practices were used by the organizational provider.

XI. EXTERNAL AUDITS

At the completion of the first year of adoption of this Compliance Policy, and for two (2) consecutive years subsequently, Keystone will undergo an external audit of the effectiveness of this policy by an accounting, auditing, or consulting agency with expertise in credentialing (other than the National Committee for Quality Assurance.) The auditing agency will evaluate Keystone's credentialing policies, procedures, and reports, its mechanisms to maintain credentialing data integrity and confidentiality, its capabilities for data collection, internal quality assurance processes, the health care provider application process, and the reporting process for health care provider disciplinary actions. The audit will include a review of valid random samples of Keystone's and its delegate's credentialing files, and all of the organizational provider's credentialing files reviewed by Keystone. The audit will be done under the guidance of the Credentialing Compliance Officer and will be carried out within 90 days of the completion of each year this policy is in effect. The draft report will be delivered to the Credentialing Compliance Officer and Keystone's Chief Medical Officer for review and comment. The final report will be presented within 120 days to the Keystone Board of Directors. A copy of the external report will be forwarded to appropriate designees of CMS and DOH.

For CMS the designee is

Gary Bailey
Director, Health Plans Benefits Group
CMS
Mail Location C4-22-27
7500 Security Boulevard
Baltimore, MD 21244

Attachment 1 - Practitioners included in scope of policy

Practitioner Type
Practitioner Type
Audiologist
Chiropractor
Dentist
Licensed Clinical Social Worker
Midwife
Occupational Therapist
Optometrist
Physician (MD and DO)
Podiatrist
Professional Counselor
Psychologist
Speech-Language Pathologist
Physical Therapist
Licensed Social Worker
Other Masters Prepared Therapist
[3]

[3] *Keystone will include physical therapists within the scope of this policy notwithstanding Keystone's position that physical therapists do not practice independently under state law.

[4]**Attachment 2**
Standards for Access and Availability
Access

Appointment Availability Primary Care Practitioner
Emergent Immediate
Urgent 24 hrs
Routine 2 weeks
Routine Physical 4 weeks

Appointment Availability Specialist, Chiropractor
Routine:
Cardiology, Orthopedics 2 weeks
Ob-GYN1 month
Other IM or surgical specialty 2 weeks
Podiatry 2 weeks
Chiropractor 2 weeks

Urgent:
Cardiology, Orthopedics 24 hours
Ob-GYN 24 hours
Other IM or surgical specialty 24 hours
Podiatry 24 hours
Chiropractor 24 hours

Minimum number office hours/week for practice

PCP
Solo 20 hours
Dual 30 hours
Group 35 hours
Specialty 12 hours
Chiropractor 20 hours

Capitated Podiatry Offices are required to have a minimum of 20 hours per week

PCP, OB-GYN and high volume specialists are encouraged to have at least one evening or weekend sessions/practice/week (included in B)

[4] The term Other Masters Prepared Therapists includes those participating mental health practitioners who provide therapy services to Keystone plan members. The specific titles of mental health practitioners vary by jurisdiction. Regardless of title, it is Keystone's policy to credential, in accordance with the provisions of this Policy, mental health practitioners who provide therapy services independently under state law.

Maximum number of patients scheduled /hour/ practitioner

PCP, Podiatry, Chiropractor 6 patients
Specialty 4 patients

E. Internal waiting time Less than 30 min.

F. A sufficient number of practitioners will be contracted to allow for access within a thirty mile / thirty minute commute for rural areas and twenty mile/twenty minutes for urban areas.

Availability

A. Coverage 24 hrs/day/7 days/week

Covering practitioner is a Network practitioner

Practitioners utilizing answering machines for after hours service are required to include the following:

Urgent/Emergent instructions are the first point of instruction

A telephone number or instructions for contacting covering physician

B. After hours phone response for urgent Within 30 problem minutes

C. No Show Documented in medical record